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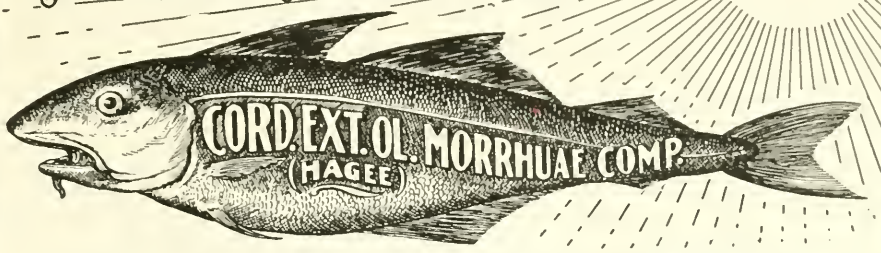

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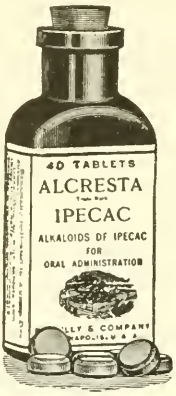

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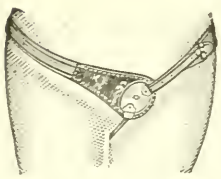

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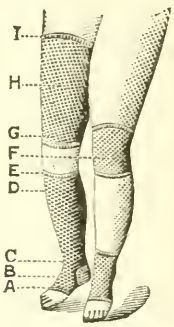

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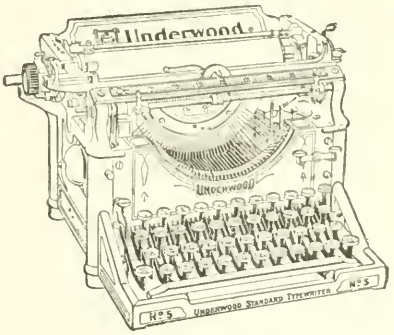

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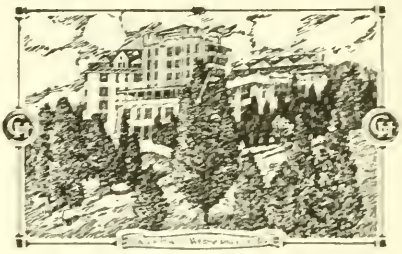

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CANCER OF THE SKIN.

By T. Caspar Gilchrist, M.D.,
Clinical Professor of Dermatology, Johns Hopkins University.

THE keynote to the whole question of cancer is early diagnosis. If this disease were accompanied by severe pains in its earliest stages, the large majority of patients would undoubtedly be cured by modern methods or treatment. It has been said that there are three stages of the disease: (1) when the patient does not know what is going on, (2) when the family doctor is not sure of his diagnosis and in many cases does not suspect cancer, and (3) waiting to decide what to do after the diagnosis is made by the surgeon or specialist. To correct the first the public ought to be trained to seek the doctor early. To correct the second the doctors during their student course should be better trained in dermatology.

The definite diagnosis in so far as skin cancers are concerned ought to be made by the dermatologist, and not by the surgeon, because the former is familiar with other similar affections and the surgeon is not. The majority of practitioners who have come for post-graduate courses in dermatology have generally made the remark that they know less about skin diseases than about any other branch of medicine. The teaching cannot be entirely at fault, because it consists mostly of demonstrations of cases; but a good deal of the weakness of the doctor's knowledge is due to the fact that, instead of attempting to first diagnose the case himself, as he ought to be trained to do, the cases are described and diagnosed by the lecturer, after which the students do not examine the patients thoroughly enough to remember them. Again, enough emphasis is not laid on the frequent demonstrations of the common eruptions, including all the varieties of the early stages of cancer of the skin.

In my experience, I find that the practitioner more frequently thinks first of lupus vulgaris (tuberculosis) as a possible diagnosis of a chronic ulcer, especially of the face, whereas that disease is very uncommon as compared with the frequency of cancer or syphilis.

In commenting upon cancer of the skin, one really cannot do better than present the chief diagnostic points of the various forms of skin cancer and the other common ulcers for which it is mistaken.

I. *Cancer.* Definition. Cancer is a special new epithelial cell growth which overcomes normal resistance, has a destructive tendency and may form metastases.

Epithelioma. Term usually applied to skin cancers, of which there are two main types: (a) squamous cell, (b) basal cell or rodent. Epithelioma is frequent in middle or old age; usually single lesion; begins in scaly spot, excoriation, fissure, nodule, wart or mole; frequently result of chronic irritation.

(a) *Squamous cell type*—more malignant variety. Often begins as a pinkish or white skin nodule, growing upward and downward; has an elevated, indurated border; has slight viscid discharge streaked with blood (because bleeds easily); surface nearly always crusted and underneath crust, like coarse granulation tissue; new growth more than ulceration when near surface; slow growth and finally often leads to enlargement of nearest glands; situated usually about eyelids, nose or lips; in early stages no pain, later painful.

On Lip. Any persistent localized thickening or abrasion or fissure of several months' duration is very suspicious of epithelioma. Later lesion consists of raised, irregular, indurated growth with coarsely granular and crusted surface; bleeds easly; nearest glands frequently enlarged; microscopically shows pearl nests, which are absent in rodent ulcer.

(b) *Rodent Ulcer* (basal cell). Usually situated about temple, eyelids and nose; superficial; shows very little new growth; apparently healing, then breaking down again; spreads very slowly, with little or no elevated edge; in some stages narrow, pearly-white, roll-like border; ulceration may last years; no glandular enlargement; when invades eye socket, can destroy whole eye; practically painless.

Non-ulcerative Form of Rodent. Has a firm, slightly raised, rolled edge with scarlike atrophic center; very chronic and very slow-growing; section from margin reveals nature of growth.

Treatment. Radium, X-rays, excision when feasible.

II. *Syphilitic Ulcers.* (a) Primary. When extragenital is most frequent on lip; more often in early adult life; rapid growth; short duration (little tendency to active ulceration); markedly infiltrated; nearest glands soon become very much enlarged; later other symptoms of generalized lues become visible; presence of spirochaeta pallida clinches diagnosis.

(b) *Late Secondary or Tertiary.* In middle or late life; frequently on face; two types—(1) nodular: one or more pea-sized and larger superficial ulcers in groups; spreads with serpiginous outline; punched out; raw-ham color; soft scarring; indurated. (2) Gummatous; deep; single; markedly punched out; indurated; necrotic base; discharges freely; bad odor; bone may be involved; painful at night; often superficially punched-out soft scars elsewhere; history of lues.

III. *Lupus Vulgaris.* Commonest form of tuberculosis of skin; rare in United States; begins in early life, rarely after 20

years; peculiar yellowish, large pinhead sized, red, infiltrated macules, points or nodules of soft consistence (probe easily pushed in); most frequent situation on face; very slow course; very chronic; ulcers shallow; scanty discharge; no serpiginous outline; bone rarely involved; scar often dense, thick and tough; often tuberculous history; pressing on margin with glass slide will show presence of pinhead-sized brownish areas; microscopic sections show tubercules in skin.

IV. *Blastomycosis.* Begins as pustule or papulo-pustule; later becomes papillomatous with miliary abscesses around the margin; may spread rapidly; raised, rather soft growth with pus exuding on pressure from between papillae; autoinoculable; often see more than one lesion present; often healing with soft scars. Microscopic examination of pus soaked in liquor potassae will reveal presence of budding doubly-contoured bodies about the size, and larger, of a red blood cell.

V. *Varicose Ulcers.* Usually on lower third of leg; superficial; irregular in shape according to age; callous edge; surrounded by eczematous, deeply-reddened skin; less pains at night; marked varicose veins.

VI. *Staphylococci Ulcers. Infected.* Those not due to above causes; follow bad or neglected treatment or secondary infection of eczema, excoriations, slight wounds, vaccination, pustules, infected granulation, etc.; usually superficial; irregular; painful.

Epithelioma of the Tongue. Usually hypertrophic; no ulceration in early stage; follows leukoplakia, syphilis or dental ulcer; as mamillated tumor; irregular; larger at base than apex; surface more villous than normal; later ulcer on deeply ill-defined nodule; everted border; bloody discharge; most frequent on anterior half and edges of tongue; aged 40 to 60 years; glands enlarged; painful salivation.

Treatment. Excision, radium, X-rays.

If the practitioner is in doubt about the ulcer being syphilitic or malignant, the Wassermann test or internal antisyphilitic treatment will frequently help to clear up the diagnosis. While in doubt about the diagnosis, leave the ulcer alone, or prescribe boric ointment or other mild antiseptic applications. *Do not on any account use silver nitrate or other caustics,* because these usually stimulate the disease and I have seen many cases become very malignant and grow rapidly after such unskillful applications.

FREQUENCY OF CANCER.

In the last 20 years' experience I have come to the conclusion that cancer of the skin has not noticeably increased in frequency, but the efficiency of diagnosis has improved so much that the disease only appears to be more frequent.

Treatment. This varies according to the stage and position of the cancer. During the last six years I have obtained very successful results with the application of radium, especially when the cancer has attacked the lower eyelid, inner or outer canthus

of the eye, various parts of the nose or other parts of the face. The resultant scar is hardly noticeable, the application painless, and with proper screening of the radium no unnecessary reaction is produced. All forms of rodent ulcer can undoubtedly be successfully treated with radium. I have had 16 years' experience with the use of X-rays in the treatment of skin cancers, and have seen very many cures, the most appropriate cases again being those of the rodent ulcer type.

The use of the Coolidge tube has simplified the treatment of malignant growths by increased doses of screened X-rays, which need only be given a few times.

Complete excision of small growths in appropriate places is also good treatment, but surgical procedure is not the proper treatment in beginning epitheliomata of the eyelids and various parts of the nose.

It is now a moot question whether excision, X-rays or radium is the best treatment for early cancers of the lip. Speaking generally, treatment by X-rays in skilled hands has given as good results as surgical procedure, which has the disadvantage of causing much disfigurement. Radium, which is now being given in more intense doses and screened, is now producing excellent results. I have treated numbers of very persistent lesions of lips and tongue, which one could not definitely decide whether they were cancerous or not, but may have been precancerous lesions, with radium with marked success.

SOME FACTS WHICH THE PUBLIC OUGHT TO KNOW.

The main facts to remember about skin cancer are the following:

Cancer of the skin in its very early stage can usually be cured by appropriate modern treatment.

Fifty per cent. of all forms of cancer of various parts of the body usually come to the surgeon or specialist too late. The early stage of cancer is unaccompanied by pain, hence the reason why patient does not seek the doctor or specialist early. The best advice should always be sought.

All ulcers or growths or tumors of the skin are not necessarily cancerous, and the treatment varies according to the diagnosis.

When there is on the lip, especially the lower one, any persistent local thickening or superficial sore or fissure or crack of several months' duration, then it is suspicious of the early stage of cancer. It is very dangerous to irritate such a place by sucking or picking or putting any kind of caustic or paste on, because usually such treatment causes the disease to grow much faster and form "roots," as the public call them.

See the doctor or specialist and find out what is the best mode of treatment for your case.

Another kind of skin cancer begins as a small mole-like pimple which gradually increases in size; is firm and is more dangerous when it is colored (brownish or blackish); later it bleeds easily,

especially when scratched or pinched. It appears to heal, but after a while breaks down again and grows gradually. Soon it begins to have "roots," as lay people call them, which means that the nearest glands become diseased. This can be cured when recognized in its early stage before it has "roots." Another kind of skin cancer begins even more innocently, as in its very early stage it is like a persistent scaly spot, or as if the surface skin had been rubbed off (excoriation), or as a chronic crack, or like a wart or mole. The patient thinks nothing of this, because it looks so innocent, does not hurt at all and now and again it seems to heal and then break out. Such a cancer when near the eye can eat the whole eye out. In fact, if left alone, can destroy both the nose and eyes or attack the ears.

Ordinary moles, whether white or colored, and especially the latter, are becoming decidedly dangerous when they begin to increase in size or get irritated. Generally speaking, when moles are situated in areas which are subject to friction, then they ought to be removed.

So the advice to the public is to seek the doctor or specialist in the early stage of the disease, because the expense of treatment is then very much less and there is a much greater chance of being cured.

TREATMENT OF CANCER BY RADIUM

By Howard A. Kelly, M.D.,
Professor of Gynecology, Johns Hopkins University.

RADIUM, our newest therapeutic agent, is proving to be of the utmost value in the treatment of cancer of all kinds, whether operable or inoperable. Two of the three rays emitted by radium, the beta and the gamma rays, affect the tissues of the body most profoundly, fortunately, however, acting much more potently on the weaker cancer cells than upon the normal cells of the body. No one claims, and no one ever has claimed, that radium would cure all cases of cancer; that erroneous statement was due to the daily newspapers, hunting for something dramatic for their columns.

Radium has, however, won for itself a definite place in cancer therapy, and with time and experience, and above all with increased amounts of radium and newer methods of applying it, its domain over this dread realm will undoubtedly extend from year to year. I include under the broad term cancer, sarcomata, as well as epithelial growths.

Radium therapy is analogous to X-ray therapy, with the striking differences that radium is far more potent and less likely to cause any irritation or injury to the sound tissues. Radium acts more speedily than X-ray; for example, it is the rule to finish the treatment of a fibroid tumor with one or two applications of

radium, while many X-ray treatments are called for, extending over weeks or even months.

At first the question was, "Does radium really cure?" but now that query can be answered positively and in the affirmative after the lapse of years. This fundamental matter has also been set at rest by autopsy made years after radium treatment.

Cancers of the skin are most amenable to radiation. The only obstinate and refractory group of cases here is those which have existed for years and which have been treated by cautery, caustics, etc. Those cases are also obstinate which have invaded the deeper tissues, or which have extended through and involved the mucous surfaces. The most obvious advantages of radium are seen in cancers around the eye, the ear, the lips, the nose, where the healing takes place without mutilation, in marked contrast with exsective surgery. Even where there has been extensive ulceration, there is often a surprisingly good restoration of form.

The entire surgical world has been startled by the results secured so rapidly in treating with radium that hitherto hopeless group—the lympho-sarcomata. Here great tumors, interpenetrating all the anatomical structures of the base of the skull, the neck or the chest, literally melt away in a few days' time. The rays act like myriads of microscopic knives, attacking every individual invading cell, while sparing normal tissues.

Many other sarcomata are also helped in a remarkable manner, but not in such a large percentage of the cases. Epitheliomata of the mouth, tonsils and larynx, especially the basal celled, even in totally inoperable conditions, can be cured in a fair percentage of instances.

A favorable form of cancer is that of the thyroid gland. Thymus growths of the small, round, cell type are often amenable to ray treatment.

Lip cancers yield more and more as our experience grows, but this does not obviate the necessity of a block dissection of the neck.

All breast tumors respond in some measure, the larger medullary form being the most susceptible. The best rule here is operation first when feasible and radiation afterwards.

Cancer of the vagina usually disappears rapidly under radiation.

I am glad to report that cancers of the cervix are among the most amenable to radium therapy, and this remarkable statement holds good not only for the early, but even for the later cases where the disease, though massive, still remains localized.

In nearly 30 per cent. of the inoperable cases the disease has disappeared under efficient radiation with large amounts (400-600 mg.) of radium element. This was true in a group of over 200 of our cases. It is a common sight to witness, too, the disappearance of a growth recurring in the vaginal vault after operation. It is a question for the next three years to settle whether we will continue

to operate on many of the group of cases which melt down under our radium therapy.

Up to the present radium has been used repeatedly to shrink an inoperable growth down and then to operate radically.

Finally, in concluding this brief résumé, let me say that while radium manifestly ought to replace surgery in many instances, and while it does some of its best work in curing cases which surgery has not the remotest hope of touching, yet on the whole there remains a large place for radium combined with surgery, either by following the surgical operation with radiations to reach nests of cells which the surgeon has not been able to eradicate, or to immunize the tissues, or to remove a growth which shrinks but does not disappear, or to treat recurrences. With such a brilliant present, who can declare what the future for this new and most potent agent may be? May we not legitimately look forward to a development as great as that we have witnessed in so short a term of years in the field of X-ray therapy and examinations?

June 1, 1915.

UTERINE CANCER CLINICALLY CONSIDERED.

By T. A. Ashby, M.D.,
Professor of Diseases of Women, University of Maryland.

In uterine cancer, as in all other conditions, there is a beginning. A precancerous stage is suggested by certain local indications, but cannot always be demonstrated by local signs and symptoms. Erosions and lesions on the cervix may attract attention, and neoplasms in the uterus undergoing rapid growth may appear suspicious, but the cancer cell can only be shown by microscopic investigation, and may not be found in these early stages. These local lesions may demand removal apart from the presence of cancer, and the surgeon may in this way anticipate the development of a malignant growth. It is advisable in these cases to act on an assumption and not to wait for later changes.

It is an unfortunate circumstance that cancer of the uterus, as cancer in other organs, is a treacherous condition in its incipiency and presents few symptoms of its early presence.

It may make considerable progress in the uterus before there are reliable symptoms to attract either the attention of the patient or of her physician. Yet, on the other hand, there are indications in the very early stages which should arrest attention and call for a most careful investigation.

A clinical study of uterine cancer will show chiefly two varieties—those which begin in the cavity of the body and those which have their primary development in the canal of the cervix or on the cervical mucosa. There are two distinct families or types which show preference in their origin and a distinct etiological

significance. Their origin seems to depend upon entirely different influences, which, no doubt, account for their location and selection of subjects.

To understand fully the nature of uterine cancer we must divide womanhood into two classes—those who bear children and those who do not bear children. The child-bearing woman is exposed to local lesions in the cervix which are not found in the non-child-bearing class, and it is in these local lesions that we most frequently find a type of malignancy which seems to be influenced entirely by the local condition. Just why this is so the pathologist has not been fully able to explain, unless he admits that a local irritation long existing is an etiological factor.

From the standpoint of the clinician this local influence is so clearly shown that he must admit that an exciting cause is present in the larger number of his cases and he is able to trace the origin of the process to a local lesion.

The malignant type so often found in the child-bearing woman is the epithelioma, which is almost invariably confined to this class, and is, in my experience, seldom found in the non-child-bearing class. The epithelioma first attacks the cervix, and only extends by continuity of tissue to the body of the uterus and adjacent structures. It almost invariably has its origin in an old laceration following an abortion or labor at full term.

A local lesion in some form is present, and from this lesion the malignant growth begins and spreads. The extent of the lesion may or may not have a causative influence, but it is a clinical fact that a very small tear following an abortion may be the nidus for the development of an epithelioma. This has been shown in a case which has come under my care within the past three weeks, where an epithelioma began in a small lesion following an abortion which took place several years ago.

The growth began in the lower cervix and had extended to the junction of the cervix with the body, but had not reached the cavity of the uterus.

Whilst the lesion in the cervix had been of long standing, the malignant growth has been of recent development, as the symptoms have been of short duration. The initial symptom in this case was uterine hemorrhage, which led to an early examination and prompt diagnosis, followed by an immediate operation for the removal of the uterus. The epithelioma was confined to the cervix and had extended up the canal to the internal os. It was possible to do a vaginal hysterectomy and remove, to all appearances, the entire growth, yet future developments must show whether a recurrence will take place.

The epithelioma is a less malignant type than other forms of malignancy, and if removed before it has had time to extend to the adjacent structures a cure may be expected. It extends by direct invasion and only by metastasis in its advanced stages; hence the great importance of discovering the condition in its

very beginning. It is unfortunate that its early symptoms are often overlooked and that the disease may have made extensive progress before it arrests attention. A few years ago a woman came to me for examination for a menorrhagia which had existed only a few months. She was apparently in perfect health and had paid but little attention to the unusual loss of blood during menstruation. There was no pain, no foul discharge and no symptoms to cause her alarm or distress. Upon examination it was found that the epithelioma had completely destroyed the cervix, had invaded the body, and that the vaginal walls were already extensively involved. It was simply impossible to do a radical operation in her case. This is the history of many cases of uterine cancer, and it, no doubt, accounts for the fact that the surgeon is so seldom called to see cancer cases in their primary stages. Whether my own experience corresponds with that of other surgeons I am unable to say, but I feel sure that over 80 per cent. of cases of uterine cancer that have come under my care in the years gone by have been so far advanced that a radical operation was impossible.

Where it has been possible to get the case in the early stage and to do the radical operation the results have been entirely favorable. The mortality in the early stages is practically nothing, and recurrence has never followed at the original site of the growth. This has not only been true in cases of epithelioma, but in the adeno-carcinoma and other types.

As the epithelioma almost invariably begins in the cervix, and is found almost entirely in the child-bearing woman, there is the greatest need of prompt action in diagnosis and in treatment.

The insidious nature of the disease should keep the physician and also the patient on the constant watch for the early symptoms of the disease. It is important to recognize the precancerous stage, if possible, by taking notice of local lesions about the cervix, by a study of the hereditary elements in the given case and by a constant watch on menstrual disturbances.

No one will assume that uterine hemorrhage is always due to uterine cancer, yet it is clearly necessary to act on the assumption that the cause of hemorrhage is a matter for investigation and possibly for operative treatment. Hemorrhage from the uterus is due to so many different causes that we must feel assured that cancer is not present in the case under observation. This assurance can only be established by a careful investigation of the case. We cannot trust to drugs or to an expectant plan of treatment. The observation must be careful, painstaking and direct.

Adeno-carcinoma is, perhaps, the most malignant type of uterine cancer and the most insidious in its origin. There is no precancerous stage that can be recognized. It has its origin in the vast majority of cases in the mucous layer of the uterine cavity. I have never seen a case that did not start primarily in the cavity of the body and then extend to the cervix or to the muscle wall

or adjacent structures. Beginning in the mucosa, it invades the muscle wall and extends by metastasis to the pelvic glands or to neighboring tissues. If discovered before the muscle wall is seriously involved and metastasis has not taken place, the uterus can be removed and a cure effected. A case in point will illustrate this statement.

Nineteen years ago a young woman came under my care with the following history: She was a student of medicine and a very intelligent girl. She had noticed an unusual flow of blood at the menstrual period and consulted a physician, who advised a curettement, which temporarily relieved the excessive flow. After a few periods her menorrhagia returned and a second curettement was done. The scrapings only indicated a catarrhal condition of the endometrium. A few months after the second curettement the menorrhagia again returned. She then came under my care, and I suspected a beginning malignancy and advised a curettement, to be followed by a pan-hysterectomy if the scrapings gave any indication of cancer. I curetted the uterus and found a few scrapings, which, upon careful examination by an expert pathologist, were found to be from an adeno-carcinoma. I promptly removed the uterus by a vaginal hysterectomy. The uterus had not enlarged, but at the fundus a small ulceration of the endometrium had taken place, and a further examination by the pathologist showed a well-marked cancerous condition.

This patient made a prompt recovery and has had excellent health since. It was my good fortune to meet her a few weeks ago in a Southern city, where she has practiced her profession with much success. This is only one of a number of similar cases that have come under my care in time to do the early operation and get a positive cure. I am forced, from a large personal experience and from the experience of other surgeons, to insist upon the fact that adeno-carcinoma, as the epithelioma, is a curable condition if removed in the very early stages. We may hope for the best results in the early operations, for it will be found that recurrences will be rare if the condition is radically removed.

The sarcoma, in my experience, is a rare condition in the uterus. It has a precancerous stage which is not always recognized as such, but has much to do with the infrequency with which it is met. The sarcoma begins as a myoma or fibroma in its physical aspects, and can seldom be recognized in its true nature unless it has assumed an advanced stage. It is more rapid in its growth than the innocent fibroma or myoma. This characteristic feature should arrest attention and lead to a prompt interference. Whatever view we take of the so-called innocent fibroid of the uterus, the growing experience of the surgeon clearly condemns these tumors to the fate of the knife. Whilst often innocent enough in their clinical symptoms, they invite trouble in many ways and lead to much invalidism in many pa-

tients. Surgery presents such a safe and prompt relief for them that few women will consent to carry them through life when assured of the comfort which comes through their removal and possible danger which comes through their presence.

The cause of cancer is little better understood today than in the time of Hippocrates. Whilst great efforts have been made in the past and are now being employed to discover the true nature and influences which give rise to cancer, no satisfactory results have been reached, and we are still in the dark. The many investigations which are now being made may, we hope, ultimately lead to a correct understanding of its etiology, but until this fact is fully established the condition must be considered almost entirely from the clinical standpoint.

The treatment of cancer is strictly surgical, and the best results which have come have been reached through the use of the knife. As unsatisfactory as these results may appear, the failure of surgery can be fully explained, and its satisfactory results can be demonstrated. Experience has clearly demonstrated the fact that cancer is a curable condition if removed in its primary stages. That surgery so often fails is due almost entirely to the fact that the disease has not been recognized and removed in its primary stages when it attacks organs accessible to the knife.

From the clinical point of view the one fundamental fact remains that the early diagnosis and removal of the cancer is the only hope for the patient and the only promise of surgery. Until this fact is generally recognized incurable cases will in the future, as in the past, continue to lock the wheels of surgery.

SOME OBSERVATIONS ON DIAGNOSIS OF CANCER OF STOMACH.

By Thomas R. Brown, M.D.,
and
Ernest H. Gaither, M.D.

Of all varieties of carcinoma, none has been so singularly devoid of successful treatment, medical or surgical, as carcinoma of the stomach, and yet of all classes of malignant disease this is one of the commonest to be met. The correct diagnosis of late cancer of the stomach is, as a rule, not difficult, but at this time curative treatment is absolutely impossible, and even palliative treatment often difficult. It is obviously of paramount importance, therefore, that if we hope for successful treatment, in other words, for early surgical removal before metastasis has begun and extension is marked, it is essential that an early correct or at least probable diagnosis must be made.

It has seemed to us, therefore, very pertinent to discuss in this short article some of the methods brought out in the hope of reach-

ing a correct diagnosis and then discussing our own results in this connection, devoting our attention especially to the value of the study of the soluble proteid contents of the gastric contents as a criterion. It is perhaps not generally known how great is the prevalence of gastric carcinoma, and how large a role it plays in cancer mortality. According to various statistics, some extremely large and running over a long period of years, cancer of the stomach represents from 25 to 50 per cent. of all carcinomata, and according to other statistics these figures are increasing rather than decreasing, probably due, however, to better methods of diagnosis. Until the development of modern surgery gastric carcinoma was obviously of no interest except diagnostically, as cure was out of the question. With the marvelous development of gastro-intestinal surgery and with the possibilities of radium and possibly of various colloidal metals in the destruction of cancer cells, the treatment of cancer of the stomach assumes a much greater significance, although one must admit that with the exception of that group of cases of resection of ulcer, in which the pathological study shows beginning carcinoma, the successful results have been extremely meagre. Of course, there are certain symptoms which should always make us suspicious of gastric carcinoma—the sudden development of dyspeptic symptoms in persons over 40 in whom digestion has been normal up to that time; a loss of appetite, especially to meat, without apparent cause; the change of an ulcer picture from hyperacidity to hypoacidity; the persistent finding of occult blood in the stools with a negative rectal picture and in the absence of signs and symptoms of ulcer or in supposed ulcer after careful treatment—all of these should always make us consider the possibility of an early gastric cancer and weigh very thoughtfully the advisability of exploratory operation, but even in such cases by the time operation is performed the growth has usually reached such an extent and glandular involvement is so probable that a successful issue is extremely doubtful. In this connection the views of Rudolph Schmidt regarding suspicious symptoms are very pertinent:

"1. Unaccountable occurrence after the thirtieth year of gastric symptoms, such as pressure in the stomach, eructations, etc., in an individual previously favored with a healthy gastro-intestinal tract (gastro-intestinal athletes).

"2. Given the same gastro-intestinal individuality, a disproportion between cause and effect in so far as the accused dietetic error gives rise to strikingly stubborn stomach complaints.

"3. Rapid diminution of gastric tolerance in a stomach athlete, e. g., when soon only milk and soup are well borne.

"4. Long duration of occult intestinal hemorrhage in suspected ulcer despite proper treatment with prolonged rest in bed.

"5. As certain forms of gastric cancer begin and continue with the typical subjective symptoms of peptic ulcer, and as the treatment of ulcer will also produce apparent cures in these cases, it will

always be advisable to make the diagnosis of gastric ulcer with reservation. Personally, I consider this reservation especially appropriate in cases where we are dealing with strong individuals previously enjoying good digestive energy between the ages of 40 and 50. Such patients should be warned of the possibility of a malignant ulceration so that they place themselves under continued observation.

"6. Finding of sarcinae in stomach contents or faeces when stomach ailments are of short duration, denoting a rapid development of pyloric stenosis.

"7. Stubborn obstipation in an individual who has been hitherto regular."

Then we must not be deluded by the fact that the patient shows marked improvement under proper rest and dietetic therapy that the case is not one of carcinoma, for this in our experience often occurs in these cases, and frequently for a surprisingly long period of time. A negative point worthy of being remembered is that constant negative findings of occult blood in the stools speaks against cancer.

We must not forget that in many cases of gastric cancer, especially those involving the curvatures far away from either antra, the growth may become extremely large before the development of any symptoms, either local or general, while in other cases the gradation from a previous benign to a malignant gastric condition may be so gradual as to be almost imperceptible. What, then, are the tests which have been found helpful in reaching an early diagnosis of gastric cancer? Many in number, it is true, but lamentably few in results!

Broadly speaking, these tests may be divided into—

1. Those based on the theory that in the growth of the cancer cell a proteolytic enzyme is formed, which will tend to bring about lower products of cleavage of the proteid molecule than normally met with in the gastric contents, these products to be estimated from the study of gastric contents or of the urine, or by the effect of the gastric contents upon special proteids.

2. Those tests based on the theory that in the growth of the cancer cells certain anti-bodies are found in increasing or decreasing amounts in the circulating blood, this being the basis of the antitrypsin test used very extensively in certain clinics.

3. The discovery of definite signs of gastric ulcer on the basis that this is potentially gastric cancer, and that every correct diagnosis of the former should be followed by surgical removal in the hope of preventing the latter.

4. Tests based on the idea that the gastric cancer in its development will produce certain morphological changes in stomach contour to be made out by radiographic and fluoroscopic studies, the persistence of a filling defect in repeated studies at one point being extremely suggestive of some definite organic lesion, usually carcinoma or callous ulcer, and either warranting surgical interference.

5. Tests based on Abderhalden's principle, which have been carried out rather extensively in certain of the Vienese clinics where emulsions of cancer cells freshly obtained from the pathological laboratory can be so easily obtained.

Of these various methods of testing we have had some experience with the antitrypsin, the glycyltryptophan, Salkowski, Saxl and Saloman, and Gluzinski methods, but none of these has given us such satisfactory results as our experiments with the Wolff-Junghanns test for soluble proteid, a simple clinical method of estimating with comparative exactness the amount of soluble proteid in the acid-free gastric contents. Our experience with the early diagnosis of gastric carcinoma by means of the fluoroscopic examination of the stomach has been almost entirely sterile of results, although as a confirmatory sign in the late diagnosis it has often proved of real value diagnostically, although obviously of slight importance therapeutically. If we wait until the patient is markedly anemic, until loss of weight is extensive, until toxic or obstructive symptoms are found, or until there is a palpable tumor, obviously our diagnosis is only of academic interest in so far as help to the patient is concerned. We have not found the presence of lactic acid or Oppler Boas bacilli of very great importance, as both are found so extensively in achylias of benign nature due to a variety of causes, and especially where there is any pyloric obstruction, and there is no question whatsoever that the absence of lactic acid does not in any way exclude the possible presence of gastric carcinoma. The same may be said in regard to hydrochloric acid; while its diminution or absence is the rule in the great majority of gastric cancers, nevertheless, we have seen cases in which hyperchlorhydria and gastric carcinoma were coexistent.

It has, however, been our experience that the persistence of occult blood in the feces on a meat-free diet, and with the exclusion of other obvious sources of blood, as bleeding gums, typical gastric ulcer, and bleeding hemorrhoids is of really greater value.

The test for the soluble proteid in the stomach is based on the same principles on which most of the tests of the urine or of the gastric contents in this disease are founded, namely, that the cancer cell contains in itself or forms in its growth or destruction or by its action upon contiguous substances, an enzyme definitely proteolytic in nature. This test was first brought out in the *Berliner klinische Wochenschrift* by Wolff and Junghanns, two assistants of Ewald at the Augusta Hospital, and the results of their studies so closely harmonized with the subsequent clinical or operative findings in the cases reported that they seem well worthy of further study by other observers. After being informed through one of us who was returning from Ewald's laboratory of this test, Smithies carried on an extensive series of investigations at the Mayo clinic, and concluded that the test was one of very great value in this connection, his conclusions in full appearing in the *American Journal of the Medical Sciences*. Our experience, while

by no means so extensive, has been sufficiently productive of results to warrant attention being called to it.

From the study of upwards of 200 cases of achylias of various types, some benign and some malignant, the test has been positive in over 80 per cent. of cases subsequently determined to be malignant, and positive in no more than 10 per cent. of cases in which subsequent history showed beyond question that the condition was benign. These figures are certainly sufficiently striking to warrant the systematic employment of this test in all cases in which free hydrochloric acid is absent in the stomach after the Ewald test meal. Unfortunately, the test is obviously not applicable where free hydrochloric acid is still present in the stomach, and therefore in the broader sense is not a test for the very early recognition of gastric cancer, but we know from clinical studies that so many cases show a disappearance of free hydrochloric acid as a comparatively early symptom that we feel that the test is well worthy of employment, and that there is real hope that in some cases, at least, it may result in operation followed by complete removal in a certain if small percentage of cases.

Perhaps it might be of interest in this connection, on the one hand, to describe the details of the test briefly, and, on the other, give a short review of the conditions in which achylia may be met. In regard to the test itself filtered gastric juice after the ordinary test meal is diluted one-tenth, one-twentieth, one-fiftieth, one one-hundredth, one two-hundredth and one four-hundredth, with distilled water, and then there is floated on the surface one c. c. of the reagent, which is simply a solution of definite strength of phosphotungstic acid. A positive reaction is a white albuminous ring at the junction of the two fluids, and this positive reaction may be met with normally in dilutions of 1-10, 1-20, 1-50, while, on the other hand, if it is present in dilutions of 1-200 or 1-400 it speaks very strongly for malignancy.

In regard to achylia it is a loose term, for while really meaning absence of hydrochloric acid, pepsin and rennin, in reality it is usually employed to mean the absence of free hydrochloric alone. Broadly speaking, it may be met with in various inflammatory conditions of stomach, such as catarrh, as an expression of atrophic changes such as we see in the senile and pernicious anemia, due to functional disturbances of the secretory nerves or to some condition causing their reflex inhibition, to a congenital absence of secretion, or to the effect of carcinoma, and here in all probability much more likely due to the toxins produced by the growth of cancer cells than to the direct destructive influences of the cells themselves.

The fact that the use of the various methods described for the early diagnosis of gastric cancer have led to so few cures is no argument that they should not be employed, but rather a suggestion that by widening the scope of these tests and by refining the methods of examination, chemical, physical and biological, we may possibly discover a method by means of which an early diagnosis of cancer is really possible.

CANCER OF THE RECTUM.

By J. Dawson Reeder, M.D., F.A.C.S.,
Baltimore, Md.

In the group of cases which come under the care of the rectal and intestinal surgeon a brief analysis causes him to ponder as to the frequency with which malignant conditions are met and to analyze this apparent increase from two distinct sources. Is the increase due to our being better trained to make such a diagnosis, or is cancer really on the increase when we consider the percentage per population? With our present-day training of students in the clinics and lectures, this subject is being constantly impressed upon them of the importance of a thorough history taking, as well as examination of the patient, assisted by our improved methods and instruments. How many men in our various medical schools up to a very recent date ever had the opportunity of looking through a procto-sigmoidoscope, or had been impressed with the importance of insisting upon the examination of the patient who presented himself with the time-worn self-made diagnosis of internal bleeding piles?

Vital statistics show an alarming increase in the prevalence of carcinoma throughout the civilized world. Williams (*Liverpool Chirurg. Jour.*, 1895) has shown that the disease has increased in England and Wales from 1 in 5646 in population in 1840 to 1 in 403 in 1894. The proportion of deaths from cancer to those from all other causes in 1840 was 1 to 129, and in 1894 it had increased to 1 in 23.

In the city of New York in 1890 the death rate from cancer was 1 to 1679 in population, and in 1900 it had increased to 1 to 1394.

Parke (*Practitioner*, 1899), in discussing this rapid increase in malignant disease in the State of New York, says: "If for the next 10 years the relative death rate is maintained, we will find that by 1909 there will be more deaths from cancer in the State of New York than from tuberculosis, smallpox and typhoid fever combined."

From carefully compiled data from many writers from as many countries sufficient evidence has been accumulated to convince the most optimistic that cancer is increasing. (Tuttle, "Diseases of Rectum and Colon," page 760.)

These facts are especially convincing when we study the increase of malignant degeneration in the rectum and sigmoid. Once cancer is established, it either spreads by direct continuity or is carried to other organs by the lymphatics and circulation. Notwithstanding the fact that the different countries must realize that the mortality from cancer is as great as that of tuberculosis, very little effort is brought to bear by the authorities to give support to a rigid and painstaking investigation. Carcinoma may develop in any part of the body where epithelial cells are found;

such locations as the breasts, uterus and skin are particularly prone, and the investigations of Leichtenstern show that 3 per cent. of all cancers occur in the rectum, and 80 per cent. of all cancers of the intestinal tract are located in this organ. Zemann and Wessenschafter found in 21,624 autopsies at the Vienna General Hospital 1744 cancers. Of these 912 were in the digestive tract, 9 were in the small and 156 in the large intestine. Of the latter 30 were in the sigmoid and 81 in the rectum. Heimann found, of 20,054 patients who died of cancer in the general hospitals of Prussia, 10,535, or over 50 per cent., involved the gastro-intestinal tract. Of these 2910 were in the intestine, 1204 being confined to the rectum. From these and other figures one must conclude that cancer of the rectum and sigmoid form a larger percentage of the sum total than is generally admitted.

The question of heredity is firmly grounded in the popular mind, and the unusual number of cancers seen in recent years in young people certainly adds color to this belief, especially as to the predisposition, and no doubt many cases are more thoroughly examined when such a history is obtained as it more prominently suggests itself as one of the possibilities to be eliminated by careful and painstaking examination that might have otherwise been passed over.

In my judgment, too much stress cannot be laid upon the symptoms of early cancer, and personal experience in this line has been a very sad chapter. I have endeavored to get complete histories of 22 cases of cancer, which I have diagnosed, covering a period of five years. I have written either to the family or the physician who sent them for diagnosis, and it is sad to relate that 21 of the 22 cases are now dead. This list, of course, is a record of cases that I have been asked to proctoscope either in the wards of the hospital or have been brought to my office by their physician for proctoscopic diagnosis, and in most cases was simply done to have their diagnosis confirmed. In justice to my report, I must add that these cases were well defined when examined, and the great majority were, in my judgment, inoperable at the time. This only serves to emphasize the importance of the early recognition of precancerous symptoms by both physician and patient. No rectal distress of the mildest character should be allowed to leave one's office without a satisfactory examination, as many a case of internal piles has been so treated, and the patient, who might have been helped, has been sent to an untimely grave.

The fact that the first symptoms of cancer may be a vague discomfort in the pelvis, symptoms of intestinal or gastric indigestion, constipation or colicky tenesmus, with or without the passage of blood or mucus, emphasizes its importance. It is not sufficient to examine with the finger three or four inches of the rectum, and if found normal to exonerate the rectum and sigmoid from any part in the train of symptoms, but a proctoscopic examination is always necessary before one can eliminate these organs.

In the active or proliferative stage the symptoms are more marked. In scirrhus or annular carcinoma gradual increasing constipation is a typical symptom; there may be colicky pain in the stomach or upper portion of intestine, and in some instances cutting pain at the seat of the growth. As a rule, however, pain is not a prominent symptom at the early stage of the disease. A slight mucous discharge slightly tinged with blood causes discomfort from accumulated gas. As the growth increases the lumen is encroached upon, obstruction to fecal passage more marked and blood becomes more profuse.

The adenoid or medullary cancer presents a different picture, as the chain of symptoms will be constipation, as a rule, not one of its features; on the other hand, there is a constant desire to go to stool, in which gas, small amounts of mucus, with or without blood. These calls range from 8 or 10 to 20 calls a day and as many at night. I have the record kept by a patient for one week, and at no time in the 24 hours did he find he could go longer than three hours without having to go to the toilet. The most noticeable feature of his record is that these urgent desires began about 2 A. M. and increased up to about midday. The patient persisted with the treatment outlined for about two months from my first visit, and finally died of exhaustion in less than three months. It is of interest to note that his mother and one brother died of the same condition, presenting about the same symptoms at about the same age, which was 52 years. In the medullary type the symptoms are more severe, pain is greater, discharge more profuse and loss of flesh more rapid. Digital examination presents an ulcerated mass, well-defined edges surrounding a deep crater-like cavity. The later stages of cancer are too well defined to present here, as well as the pathological subdivisions into which cancers are divided.

In presenting this subject no attempt has been made to discuss cancer from the etiological or pathological side, but an humble attempt is here made to quote authorities on the cardinal points that should be constantly before us in making a diagnosis on patients presenting suspicious symptoms.

As to operative measures in cancer of the rectum, no set rule can be made, and I think this also holds good as to the surgeon selected to perform such. Knowledge of the various operations advised, dexterity—call it luck if you will—certainly seems to play a rôle in a series of cases. While various operators are performing the same methods, with the same amount of skill and knowledge, there are very few who can truthfully boast of the enviable record of the late Dr. James P. Tuttle, and, perhaps, it will be pardonable if I be permitted to quote a few statistics from his wonderful report of 100 cases published in the *New York Medical Journal*, 1908:

"In this report (copyright, 1908, by A. R. Elliott Publishing Co.), which covered a period from June, 1892, to February, 1908,

the total number operated upon was 108 (eight lost in the Polyclinic fire).

"The total number of deaths (immediate) from 100 operations was 13, a mortality of 13 per cent. The known recurrences which we know will or have already ended in death are 24. The number of patients known to be living and free from disease, 41. This leaves 24 unaccounted for who have gone broadcast over the world, who may or may not have had recurrence. They were all free at last observation, covering a period of from three months to five years.

Type.	Recoveries.	Deaths.	Recurrences.
Epithelioma	4	0	0
Sarcoma	6	0	3
Papilloma	2	0	0
Scirrhus	2	0	0
Colloid	2	0	0
Adeno-carcinoma	84	13	21

Location of tumor and its influence on death and recurrence:

Site.	Recoveries.	Deaths.	Recurrences.
Under 1 inch	11	0	6
1 to 2 inches	8	0	4
2 to 3 inches	7	1	2
3 to 4 inches	16	1	4
4 to 5 inches	12	4	2
5 to 6 inches	9	0	1
6 to 7 inches	10	3	2
Above 7 inches	14	4	2

Character and technique of operations done, including Kraske (2 Kochers).

	Number—6.	Mortality—33%.
Bone flap	25	16%
Perineal	40	5%
Vaginal	3	....
Combined	8	37.5%
Abdominal	9	11%

"Kraske, including two Kochers, presents a very discouraging aspect. The high mortality here is accidental and does not afford a fair estimate of the method.

"The bone-flap method shows a mortality of 16 per cent.—more encouraging, but not what it should be with our present-day asepsis."

Perineal method is by far the most encouraging, and, after a discussion of the various methods, Dr. Tuttle explained in a most liberal and fair manner the causes of death, and in some instances taking the blame for some fault in technique.

A hypernephroma of the kidney may be mistaken for a tumor of the colon, but the presence of blood in the urine and a cath-

eterization of each ureter should be sufficient to differentiate this condition.

Actinomycosis of the bowel may be mistaken for cancer, but in 60 per cent. it is confined to the appendix and cecum.

Ulcerative tuberculosis may be mistaken for carcinoma, but when we recall that a primary lesion of the colon is so rare, and the diagnosis may be clinched by the physical examination of the chest, we are never justified in making such a diagnosis by proctoscopic findings. As to the bacteriological findings, I have repeatedly made the statement, which has always opened a discussion, that the average pathologist associated with hospital laboratories is not capable of differentiating the tubercle, smegma and hay bacillus, even with full knowledge of the acid-fast staining qualities. Lyponatous and fibromatous tumors of the rectum are slow in their growth and do not produce systemic disturbances, as cachexia or metastasis, until very late. Syphilis should be differentiated by microscopical findings.

Multiple adenomata and papillomata are very prone to malignant degeneration, and the examination of a single tumor has been shown to be benign on one side, while the other side of the same tumor had already undergone malignant degeneration. This should always be kept in mind when removing fragments of these tumors for microscopical examination.

Exploratory laparotomy is always justifiable in cases of cancerous involvement of the upper portion of the rectum for the purpose of ascertaining the nature of the growth, its involvement and possibility of removal. In early stages this procedure is practically without danger.

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Tuttle, "Diseases of Rectum, Anus and Colon."
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Book Reviews.

INTERNATIONAL CLINICS. Edited by Henry W. Cattell, A.M., M.D., Philadelphia. Volume IV. Twenty-fourth Series. 1914. Philadelphia and London: J. B. Lippincott Company. $2.00.

One hears and sees so much in the daily press these days of accounts of the twilight sleep in obstetrical cases. It is, therefore, indeed opportune to have an authoritative article on this subject from Daniel Longaker, M.D., of Philadelphia, obstetrician to the Jewish Maternity Hospital. As the subject is demanding so much

attention, we will quote liberally from his article. Like the author, we fear the overpublicity of this method of securing painless labor will be so exploited that it will fall into disfavor. Morphine and scopolamine and morphine and hyoscine have been employed to induce unconsciousness for surgical operations long ere these combinations were thought of for obstetrical practices. When first introduced for the first-named purpose they were wildly proclaimed as the coming method for rendering a patient insensible to pain during operation. Their use was declared to be without danger to the patient, but did such prove to be the case? By no means, so that today they are practically never used in surgical operations. Undoubtedly there are instances suitable to their employment. We fear the same hysteria is grasping the public and the profession concerning their use in child-birth. A reaction is sure to come, and when it does, it is liable under the present circumstances to be as pronounced as that in operations. It is not a unique experience to be called to a patient for an operative delivery when the immediate results for both infant and mother are infinitely better served by delay. The one supreme element to ovrcome many a case of dystocia is time. But to secure this necessary time in the face of personal, family and sometimes community hysteria is no easy matter. Attending physician and even consultant often yield unwisely to the demands of the patient and friends, and thus an attempted early operative delivery ends either in failure, in serious or even fatal injury to the child, and in physical trauma to the woman herself. A delay of four, six, eight or more hours, as a rule, converts such apparently difficult cases into the simplest possible, from a mechanical point of view—the question of high forceps operation becoming the easiest low forceps, feasible even in the hands of the tyro. The author then goes into the technic, causes of failure, and dangers of drug narcosis in labor. The article is, while conservative, a fair presentation of the subject. Besides this article there are a number of others on burning topics of the day.

The Curative Action of Radium. By Sigm. Saubermann, M.D., of Vienna and Berlin. Fifty pages, with 35 half-tone illustrations. Published by Radium Limited, U. S. A., 25 West 45th street, New York, N. Y.

Dr. Saubermann is one of Europe's greatest authorities on the Radium Emanation Therapy, and in this booklet he voices the results of his research work covering a period of over 11 years. It is of great interest to all physicians desirous of using radium emanation in treating those diseases which it influences. The 35 illustrations contained are in all probability the first of their kind ever shown in this country, and demonstrate clearly the effects of the rays and emanation of radium. The booklet will be sent free to our readers on application to the publishers by mentioning the name of the Maryland Medical Journal.

A Textbook of Surgical Operations. Illustrated by Clinical Observations. For Physicians and Students. By Fedor Krause, Privy Medical Councillor, Directing Physician Augusta Hospital, in Association with Emil Heymann, M.D., Chief Physician Augusta Hospital. Translated into English and Edited for American Readers by Albert Ehrenfried, A.B., M.D., F.A.C.S., Assistant Visiting Surgeon, Boston City Hospital; Surgeon, Boston Consumptives' Hospital; Assistant in Surgery Harvard Graduate School. In Six Volumes. Volume I. With fifty-five plates having two hundred and thirty-three illustrations in two or more colors and sixty-one figures in the text. New York: Rebman Company. 1915. Cloth, this volume, $6.00 net.

This volume is an exposition of the Krause method of presenting operative surgery, and includes such topics as preparation for operation, anesthesia, asepsis, after-treatment, treatment of wounds of the head, extirpation of tumors in the tissues of the face, plastic operations on the face, surgery of the eye and orbit, surgery of the ear, nose and accessory sinuses, of the trifacial nerve, including extirpation of the Gasserian ganglion. The light thinker would hastily jump at the conclusion the English-speaking peoples need no new operative surgery, as they are already supplied with an overabundance of books of this character of the highest merit. Such is to some extent the truth, but Krause presents the subject in a manner peculiarly his own. Besides, he is the devisor of so many practices in surgery that their receipt first hand is no light consideration. This volume approaches the subject in a novel way, viz., the presentation and discussion of actual cases, which are carefully followed from the beginning, through the operative procedure to the end result, thus in a way being a word picture of the text.

Krause is the foremost European proponent of the general surgeon instead of the specialist. He believes that the surgeon who confines himself to a specialty becomes lopsided. His efforts, therefore, have embraced every aspect of surgery, including the surgical specialties. One may believe this impossible of accomplishment by one man, but Krause has proved otherwise. He is a recognized surgical authority, whose writings are eagerly sought after by Europeans. We Americans are indeed fortunate to have presented to us in our own tongue the experience, investigations and deductions of Professor Fedor Krause.

Lectures on the Heart. By Thomas Lewis, M.D., F.R.C.P., D.Sc., Physician City of London Hospital; Assistant Physician and Lecturer in Cardiac Pathology, University College Hospital, London. Illustrated. New York: Paul B. Hoeber. Cloth, $2 net. 1915.

This little monograph consists of a welding of the Herter Lectures, delivered in Baltimore at the Johns Hopkins University, a

Harvery Lecture, New York, and an address to the Faculty of Medicine at McGill University, Montreal. The whole tenor of the monograph consists in an emphasizing of the importance of combining the laboratory with the clinical findings. Vast strides have been made in the diagnosticating and treatment of heart affections during the past few years. Much of this advance is due to laboratory methods applied to clinical findings. The refinements in cardiac diagnosis have therefore assumed sufficient importance to demand a separation of those methods strictly laboratory and those of practical utility. Dr. Lewis has succeeded admirably in bringing those laboratory methods of practical value into association with the clinical in the above-mentioned monograph. So much so, in fact, that every practicing physician, if he desires to keep abreast of the times, should possess the book. In it he will find many helpful suggestions and hints.

The Clinics of John B. Murphy, M.D., at Mercy Hospital, Chicago, April, 1915. Vol. IV, No. 2. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. Published Bi-Monthly. Paper, $8 per year.

This number is rendered additionally valuable by a contribution on carcinoma of the breast by Dr. William L. Rodman of Philadelphia. It is well illustrated, and gives a thorough description of his technic for breast amputation. Other sections on live subjects are bony lipping of the right acetabular margin and of the neck of the femur following a metastatic arthritis, arthroplasty of the hip, carcinoma of the colon, diffuse miliary carcinosis of the peritoneum, epithelioma of the upper lip starting in an old lupus scar, excision, plastic closure, Murphy's clinical talks on surgical and general diagnosis, etc. Again the surgical profession is given a fine treat. But what's the use of further comment? Every one now thoroughly realizes the Clinics are invaluable to the surgeon.

International Clinics. A Quarterly devoted to Clinical Lectures and Original Articles. Edited by Henry W. Cattell, A.M., M.D., Philadelphia. Vol. I. Twenty-first series. Philadelphia and London: J. B. Lippincott Company. 1915.

By this time our readers are thoroughly aware of the scope of International Clinics. Therefore, it is useless to devote any space to this aspect of the quarterly. As in its predecessors, so here we find a number of articles of more than the usual merit, amongst which may be mentioned that of "Remarks on the Diagnosis of Polycystic Kidney," by Sir William Osler; "Autoplastic Bone Transplantation," by V. A. Lapenta; "Routine of Practical Vaccine Therapy," by Horace Greeley, etc. The literary and scientific diet contained therein is sufficient and enough for the most fastidious and varied appetite.

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BALTIMORE, JULY, 1915

THE CANCER PROBLEM.

As a part of a nation-wide movement against cancer, the Maryland Medical Journal is devoting the entire space of its reading pages of this issue to the various phases of cancer; to what has been done in the past for its control, and what may be expected of the future. It makes no difference whether any particular reader subscribes to the belief that cancer is an infectious disease or whether it is due to misplaced cells, the scourge has become so manifestly on the increase that some plan of action must be evolved for its conquering. A great deal of work has been done in educating the public and profession during recent years as regards the recognition of cancer in its earliest stages and what can be expected from medicne and surgery. So far as the writer is concerned, the knife holds out the only hope of permanent cure. By knife is meant such surgical procedure as the electro-cautery, thermo-cautery, radium, etc., all of which aim at extirpation of the growth. These procedures, to be effectual, however, must be employed early in the course of the neoplasm, otherwise the chances for effecting a permanent cure become more remote. It is this lesson that the profession must drive home to the laity, if any advance is to be made in the elimination of cancer as a human scourge. This is especially true in the present unsettled state concerning the etiology of malignancy. This uncertainty as regards the agent producing cancer even leads progressive members of the profession to advise the extirpation of benign growths in certain localities which are particularly prone to cancerous involvement. For instance, it is a surgical maxim that a lump in the breast, what-

ever its character, should be removed as soon as recognized in order to forestall a possible cancerous degeneration. So in ulcer of the stomach the advance teaching is its removal if possible, as at least 60 per cent. of cancer of the stomach originate in the scar of an old ulcer. The gynecologists preach that excessive or prolonged so-called menstrual discharges in a woman after middle age should direct attention to the possibility of beginning cancer and the proctologist that bleeding from the rectum should not be passed lightly by, but a careful examination, digital, if no other apparatus be at hand, should be made. Until the etiological factor of cancer is discovered, the only hope held out for the reduction of the cancer mortality is earlier recognition of the distemper and prompt surgical intervention. Until more refined methods are evolved for the detection of cancer the profession and the laity must be constantly impressed with the fact that cancer on the surface as well as in the interior of the body always originates in some pre-existing lesion. It must be the constant aim of the profession to perfect means for the earlier recognition of these precancerous lesions, so that they can be removed before cancer has set in. At present this plan offers the best solution to the apparent or real increase in cancer mortality. The next best plan is a thorough education of the public in the symptomatology and accepted lines of treatment of cancer. Intelligent co-operation between the laity and the profession undoubtedly can to a large extent solve the cancer problem. A properly-educated public would make impossible Wainwright's citation of his experience in the last three malignancy victims seeking his advice. One was of a patient who neglected to seek medical advice when the early minor symptoms appeared; the second, of a patient who had been advised by the physician to wait; the third, that of one who had been correctly advised and refused to undergo the treatment. All three cases are now hopelessly doomed; the first by ignorance, the second by incompetence, the third by fear or neglect.

This tells the story of the cancer fight. All three could perhaps have been saved by timely treatment. Yet initial prudence on the first patient's part would have been of no avail had she gone to No. 2's physician, nor would greater knowledge on the physician's part in No. 2's case have availed had the patient refused to profit by it as No. 3 refused.

Medical Items.

Dr. Joseph C. Bloodgood left June 1st for a 10-day trip to Minneapolis and other points in the West.

Dr. William S. Thayer, professor of clinical medicine at Johns Hopkins Medical School, who was operated on recently for appendicitis, is convalescing nicely.

Dr. Thomas S. Cullen was operated on recently for gallstones and appendicitis. He is improving steadily.

Dr. Burns S. Chaffee, Baltimore, will become resident physician of the Union Protestant Infirmary, succeeding Dr. Edwin G. Davis, Baltimore, when changes in the hospital staff take place this summer. Dr. Davis will remain as a member of the staff. Dr. Chaffee has been connected with the institution for several years.

Prof. Thomas L. Patterson of the University of Maryland Medical School, has accepted the position of assistant professor of physiology in the medical faculty of Queen's University, Kingston, Ontario.

The Thomas Wilson Sanatorium, the life-saving station for sick babies during the summer, opened June 15th, for its regular three months' work of caring for children with hot-weather ailments. Thirty tiny babies were admitted the first day. The institution is situated at Mount Wilson, about ten miles northwest of Baltimore city. Dr. J. H. Mason Knox, Jr., is in charge of the sanatorium.

Dr. Henry J. Berkley, Baltimore, has been appointed a member of the State Lunacy Commission to succeed Dr. John D. Blake, Baltimore.

Dr. Otto V. Huffman, secretary of the New York State Board of Medical Examiners, has been elected secretary of the faculty and executive head of Long Island College Hospital, Brooklyn, in succession to the late Dr. Joseph H. Raymond. Dr. Huffman is a native of Dayton, Ohio, is 33 years old is a graduate of Denison University and the College of Physicians and Surgeons of Columbia University, 1903.

Dr. David K. Henderson, for the last three years resident physician at the Phipps Clinic of Johns Hopkins, has resigned and is now on his way to Glasgow, Scotland, to take charge of the Royal Asylum there.

Dr. Roscoe W. Hall, who has been serving as assistant to Dr. Henderson, has been made resident. Dr. Hall is a 1912 Hopkins Medical School graduate. Another Hopkins man, Dr. Charles B. Thompson, has been promoted to Dr. Hall's place.

Dr. Henderson had been chief assistant to Prof. Adolph Meyer, psychiatrist, since the opening of the Phipps Clinic, and is considered an authority on brain disorders. His new post is not believed more important than his position at the Phipps Clinic, but is supposed to be more attractive to him because he himself is a graduate of the University of Edinburgh.

Dr. William H. Welch left Baltimore June 30th for China, where he will join Dr. Frank J. Goodnow, and with Dr. Simon Flexner, Dr. David Moon Robinson and Dr. Wallace Buttrick, will undertake the great work of systematizing the medical education of that country. Dr. Welch will go direct to San Francisco and will said on July 5th for China, stopping at Honolulu for a short time. The others will not go until a month later.

Through the beneficence of Mr. and Mrs. Morton Samuels, as a memorial to Mrs. Samuel's parents, the Hebrew Hospital will have another handsome and substantial building added to its group. The building will be for a general dispensary.

Dr. George H. Hocking, Govans, Md., has been appointed a member of the Maryland State Lunacy Commission, to succeed Dr. Thomas H. Brayshore, Glenburnie, whose term of office has expired.

BIRTHS.

To John William Robertson, M.D., University of Maryland Medical School, '09, and Mrs. Robertson, of Onancock, Va., May 30, 1915, a daughter—Elizabeth Sue Robertson.

To Humphrey William Butler, M.D., University of Maryland Medical School, '13, and Mrs. Butler, of Canhotinoho, Brazil, S. A., in April, a daughter.

MARRIAGES.

Francis Peyton Rous, M.D., Johns Hopkins Medical School, '05, to Miss Marion Eckford De Kay, both of New York City, at New York, June 15, 1915. Dr. Dous is a member of the staff of the Rockefeller Institute for Medical Research.

Norbert Charles Nitsch, M.D., University of Maryland Medical School, '13, to Miss Ethel Marie Katzenberger, both of Baltimore,

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A Healthy Growth
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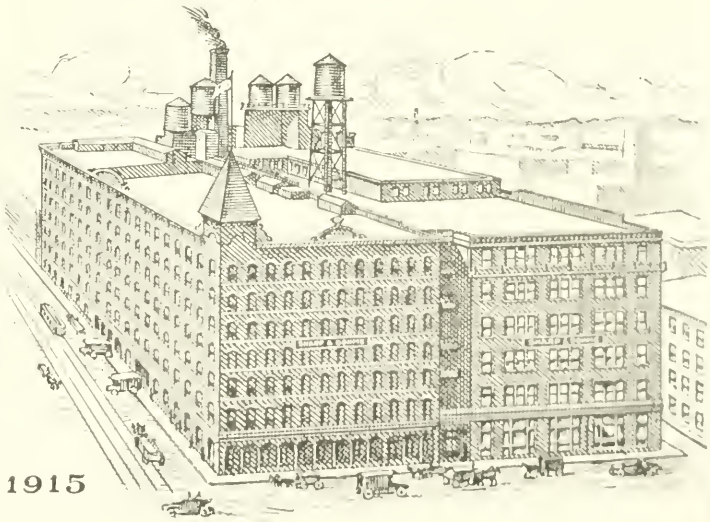

1915

THE OAK

Md., at Baltimore, June 23, 1915. For the past two years, Dr. Nitsch has been resident physician at St. Agnes' Hospital, which position he has resigned to take up active practice.

Walter S. Niblett, M.D., University of Maryland Medical School, '11, to Miss Ethel Wolfe, both of Hillsdale, Md., at Hillsdale, Md., June 9, 1915. Dr. Niblett was formerly superintendent of the Kernan Hospital for Crippled Children.

Cranford Haywood Douthirt, M.D., University of Maryland Medical School, '14, to Miss Lydia Isabelle Reid, both of Baltimore, Md., at Towson, Md., June 2, 1915. They will reside at Roaring River, N. C.

Henry Latimer Rudolph, M.D., University of Maryland Medical School, '02, of Gainesville, Ga., to Miss Annie Louise Pagett, of Atlanta, Ga., at Atlanta, June 2, 1915. Dr. and Mrs. Rudolph will reside in Gainesville.

Harvey K. Fleckenstein, M.D., Physicians and Surgeons, '04, of Baltimore, Md., to Miss Isabella Griffith, at Retirement, near Gaithersburg, Md., the country estate of the bride's parents, June 12, 1915.

Lewis Kyle Walker, M.D., University of Maryland Medical School, '11, of Ahoskie, N. C., to Miss Grace Belle Stoneham, of Monaskon, Va., at "Maidley," Monaskon, May 26, 1915.

Alexander Randall, M.D., Johns Hopkins Medical School, '07, formerly of Annapolis, Md., to Miss Edith Kreedler, of Philadelphia, Pa., at Chestnut Hill, Philadelphia, June 2, 1915.

George Ward Disbrow, M.D., University of Maryland Medical School, '13, of Newark, N. J., to Miss Virginia W. Sprecher, of Sykesville, Md., in Washington, D. C., May 23, 1915.

DEATHS.

Robert Dorsey Coale, M.D., University of Maryland, '12; Ph.D. Johns Hopkins University; for many years dean of the medical school of the University of Maryland; colonel of the Fifth Infantry, M. N. G., during the Spanish-American War and from 1886 to 1909 an officer of that regiment, died in the University Hospital, Baltimore, May 18, 1915, from cerebral hemorrhage, aged 57 years.

James Alfred Faffney, M.D., Baltimore, (Md.) University, '98, died at his home in Bridgeport, Conn., April 26, 1915, aged 39 years.

Niles Harrison Shearer, M.D., University of Maryland Medical School, '66; a member of the Medical Society of the State of Pennsylvania and American Academy of Medicine; surgeon of volunteers during the Civil War; a druggist and financier of York, Pa., died at his home in that city, May 5, 1915, aged 73 years.

David Ballantyne Anderson, M.D., Johns Hopkins Medical School, '13, of Salt Lake City, Utah; an intern in Mount Sinai Hospital, New York City, was accidentally drowned during a heavy windstorm while canoeing on Lake George, May 26, 1915, aged 27 years.

J. H. Turner, M.D., University of Maryland Medical School, '40, of Martinsville, Va., died at his home, April 1, 1915, from senile debility, aged 89 years.

James Belt Chesley, M.D., University of Maryland Medical School, '68, of Forest Glen, Md., died at his home, April 7, 1915, aged 71 years.

William H. Siple, M.D., College of Physicians and Surgeons, '90, died at his home in Petersburg, W. Va., April 4, 1915.

Frank Huske Holmes, M.D., University of Maryland Medical School, '95, of Clinton, N. C.; a Fellow of the American Medical Association, died in a sanatorium in Asheville, N. C., April 18, 1915, aged 45 years.

Jefferson D. Wright, M.D., University of Maryland Medical School, '82; a physician and druggist of Louisville, Ga., died at his home, April 14, 1915, aged 54 years.

Sherman Voorhees, M.D., College of Physicians and Surgeons, '93, formerly a Fellow of the American Medical Association and of the American Academy of Ophthalmology and Oto-Laryngology, and a specialist on diseases of the eye, ear, nose and throat, of Elmira, N. Y.; surgeon to the Arnot Ogden Hospital and local ophthalmologist for the Pennsylvania System, who was seriously injured in July, 1914, in an automobile accident, died from his injuries at the home of his sister in Brooklyn, May 1, 1915, aged 48 years.

Ira R. Wetherill, M.D., College of Physicians and Surgeons, '81, a practitioner of Bluffton, Ind., for twenty-five years, died in a sanatorium in Marion, Ind., April 21, 1915, aged 61 years.

SYRUPUS HYPOPHOSPHITUM FELLOWS

One of the most efficient, most complete, and best all-round Tonics in the Materia Medica!

For four and a half decades its reputation has been constantly increasing!

Reject < Cheap and Inefficient Substitutes
Preparations "Just as Good"

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WHY WE SHOULD HAVE A WAR AGAINST CANCER.

From the Commission on Cancer of the Medical Society of the State of Pennsylvania.

It is a fact that cancer kills about 75,000 people in the United States every year. Any disease which causes such a high annual toll should command the careful attention of the Government, the medical profession, and the people. The need for this careful attention is all the more imperative if both the morbidity and mortality can be very largely reduced by co-operation on the part of these three forces, i. e., the Government, its people, and their physicians.

The reduction that has been caused in tuberculosis is now a matter of history. There can be no doubt that similar well-directed and persistent activity would cause a similar effect in cancer.

The key to the reduction of cancer mortality lies precisely in this: That cancer always begins as a purely local disease involving a strictly limited area. Second, that this limited area is accessible in about four-fifths of all cases; and third, and most important, a commencing cancer practically always indicates its presence when it is still in its early, locally limited and permanently curable stage. In other words, the enemy that we have to fight is not the cancer, but the delay. Nearly 60,000 of our people die every year, not because they have cancer, but because they have waited till the cancer became incurable.

The causes for delay are, first, that the people know little or nothing about cancer. The layman or laywoman does not know that certain evident signs and symptoms mean that cancer is insidiously creeping on them and will be fatal unless recognized and checked in time. So that a large proportion of our 60,000 unnecessary cancer deaths occur because the people do not know. If a woman has a right to kill another human being to save her own life when attacked, how much more has she the right to know that a fatal disease has begun its attack on her? A woman who loses her life at forty simply because she never knew that irregular vaginal bleedings indicated the presence of a cancer while it was in its early curable stage certainly has not had her fair chance at the hands of civilization. If our people are dying because they no not know, we, the doctors, much teach them. We must teach women that a lump in the breast, no matter how small or how painless, may be the starting point of a serious condition and must at once be investigated by a competent physician. We must teach women that irregular vaginal bleeding, the onset of a discharge, etc., may be early warning symptoms of cancer of the uterus. We must teach all people that a mole or a wart which begins to grow, bleed, or ulcerate, is a danger sign that must be heeded at once. There are similar early signs in other portions of the body that may forewarn people, and of which they should have accurate knowledge.

There is also a great field in the conditions marked by chronic irritation and the so-called precancer lesions. Recent statistics show that in about 40 per cent. of cases the cancer, the malignant disease, was preceded by long-continued simple diseases or by some form of chronic irritation. In other words, a large proportion of cancerous people need not have had the disease at all if

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Most Select Location
Fronting the Beach

Between Steel Pier and New Garden Pier

Thoroughly modern and completely equipped. Courteous service. Bathrooms with hot and cold, fresh and sea water attachment. Orchestra. Extensive porches overlooking the Boardwalk. Always open. Golf privileges.

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the "logical supplanter of opium, and other habit forming drugs" is

PHENALGIN

No matter how severe or where located pain is promptly and satisfactorily controlled by this effective anodyne—and without disturbing the digestion, suppressing the secretion, causing constipation or inducing a drug habit.

This is why Phenalgin has superseded opium and its derivatives for relieving **Headaches, Rheumatism, Gout, La Grippe, Lumbago, Neuralgia, Disorders of the Female, Dysmenorrhea, and Painful Conditions generally.**

To thousands of physicians Phenalgin "is the one dependable analgesic—the logical supplanter of opium".

Specify "Phenalgin Pink Top Capsules".

Samples and interesting information on request

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59 Bank Street
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TUBERCULOSIS

OF THE

Lungs, Glands, Bones or Joints will be greatly benefited by the use of

PROTONUCLEIN BETA

Combining the nucleins of the spleen with Protonuclein

Attention must be paid to the marked results obtained abroad by the use of the spleen in tubercular cases.

We have combined this action of the spleen with the well-known reconstructive action of Protonuclein, meeting the modern theory of building up the body to combat Tuberculosis.

See that your prescription reads:

℞ PROTONUCLEIN BETA CUBES, GR. V.
No. 60

Sig. 2 cubes 3 times a day, one hour after meals. Chew the cubes.

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they had been forewarned and had their precancerous condition cured.

The second great problem lies with us as medical men. Are we as active in the treatment of precancerous diseases as we should be, or do we only too often put our patients off with some placebo and advise them not to worry? Do we always insist on a thorough examination when a patient comes to us with symptoms that may mean cancer? When an early cancer is present, do we always lay proper emphasis on the necessity for proper treatment at once? Do we not too often advise the one course which can yield to disaster and tell our patients to wait and see what develops, i. e., wait till the cancer becomes inoperable? Unfortunately at the present time these questions must be answered to our disadvantage. A recent extensive investigation has shown that on an average the family physician has had his cases of cancer under observation for about a year before they come to a real attempt to cure the disease. Our attitude to cancer needs to undergo a radical change. The average of one year's observation must be cut down to a few weeks, or, best, to a few days. Immediate attention to the precancerous condition, counsel in the doubtful cases, and immediate action in the positive cases, is the only proper service we can give our patients. To do this we need a campaign amongst ourselves, too. A new and more efficient spirit must be created which will result in constant watchfulness to keep our patients from swelling the thousands of untimely and unnecessary deaths from cancer.

To arouse the profession fully to the necessities in the war against cancer, a movement has been started by which, during the present few months, State and county societies all over the country are devoting special meetings to the study of cancer, and in addition the vast combined influence of American medical journalism has been enlisted, and the ——— has united with ——— other medical journals to provide for its readers special cancer numbers. It would seem from the number of journals co-operating that the message must be brought directly to every medical man. We are sure that in this way the interest of the medical profession will be aroused for years to come, and we are sure that the time will be soon at hand when no blame for participation in the fatal delay can ever be laid at the door of an American physician.

CANCER OF THE BREAST.

Carl Beck, Chicago (*Journal A. M. A.*, May 22, 1915), recommends a more extensive operation than has been used in cases of extensive recurrent and hopeless cancer of the breast. The only thing generally thought best to do is to apply Roentgen rays or Coley's fluid and morphin. In the course of the last few years he has been able to save a few such cases by the operation of exarticulation of the whole shoulder girdle, including the clavicle, arm and scapula, with the plexus and vessels of the infected side, and the ribs, should they seem invaded by the carcinoma. This method may have been used elsewhere, but the procedure is not common, and its publication may be of value. A definite plan cannot be prescribed in detail. The individual case must be considered. It is a delicate as well as an extensive operation, and attended with great shock to a person who is not often in the best

A
Rational Procedure
in
Summer Diarrhea

For Infants of any age

Mellin's Food
4 level tablespoonfuls
Water (boiled, then cooled)
16 fluidounces

Give one to three ounces every hour or two, according to the age of the baby, continuing until stools lessen in number and improve in character.

Milk, preferably skimmed, may then be substituted for water—one ounce each day—until regular proportions of milk and water, adapted to the age of the baby, are reached.

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condition. "On the whole, however, it begins with the formation of a large skin flap destined to cover the whole area of the defect, the exarticulation of the clavicle following, then dissection of the tissues of the neck and axilla in one block, ligation of every vessel as it is reached, cautious cutting on one nerve after the other, and lastly, the separation and excision of the scapula. Altogether, I have done this operation eight times in nine years. All cases were desperate; some of the patients operated on several times by myself or others were all considered inoperable, some of them having consulted the best operators of the country, who declared surgical operations useless." The cases are reported, and two practical recoveries have been obtained, while another patient did well for three years before she was lost sight of. While the results are not ideal, they were good considering the desperate character of the cases, and the most important point of all seems to Beck to be the fact that there is some hope even in these most hopeless cases, when surgery is carried to its limit.

THE CANCER PROBLEM.

By Dr. William Seaman Bainbridge.

Each successive generation has added its quota of theory to the subject of cancer, with now and then a fact to illuminate the situation, while the inauguration of what has been called the era of modern or scientific cancer research has produced books, brochures, papers and other contributions in disconcerting volume. It has been correspondingly difficult for those not actually taking part in the campaign of research, and even for those who are the real history makers in this line, to keep abreast of the times and to satisfactorily digest the mass of cancer literature.

In the preface to "The Cancer Problem" (The Macmillan Company, New York and London), the author, Dr. William Seaman Bainbridge of New York, says: "With the development of the widespread interest in cancer there has arisen a definite need for a book of ready reference, of convenient size, giving in succinct and available form a summary of knowledge concerning the subject. This is needed by the general practitioner, by the specialist, by the intelligent layman, by the lecturer on health matters; in fact, by all who are definitely interested in questions of health maintenance."

Dr. Bainbridge has succeeded in his undertaking remarkably well. Finding it necessary, as he states, "to touch upon practically every phase of the cancer problem, to state theories, to emphasize facts, to review the work and opinions of those who are qualified to speak with authority, and to maintain throughout an attitude of 'suspended judgment pending proof,'" he has shown skilful discrimination in winnowing the wheat from the chaff, the fact from the fiction.

The fourteen sections, some of which are subdivided into chapters, the final survey called "The Outlook," the general bibliography, the index of authors, and the very full index of subjects, all contain a surprising amount of valuable information concerning this multiplex question.

Practically every class of reader can find within the pages of this book subject-matter to suit his particular needs.

The statistician will find the section on "Statistical Considerations" a book within itself, full of valuable information and a

SABALOL FOR NASAL CATARRH SPRAY.

AFFORDS PROMPT RELIEF IN ALL CATARRHAL DISEASES REACHED BY LOCAL APPLICATION

Pharyngitis, Laryngitis, Hay Fever, Acute Coryza, Rhinitis, Ozena and Inflamed Mucous Membrane in All Parts of the Body

Laryngologists find SABALOL SPRAY invaluable in the treatment of the throats of actors, singers and speakers

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PRUNOIDS

An ideal laxative that acts by restoring or increasing the physiologic activity of the bowels; absolutely free from griping, distress or after constipation.

Indicated in Constipation and all forms of Intestinal Atony or Stasis.

CACTINA PILLETS

A true cardiac tonic that can be relied upon to strengthen, support and regulate the heart's action.

Indicated in Palpitation, Arrhythmia, and all Functional Heart Disorders.

SENG

A digestive secernent that has been found to be a remarkably effective stimulant of the gastro-intestinal glands.

Indicated in Atonic Indigestion and all Dyspeptic Conditions due to glandular inactivity.

SULTAN DRUG CO., ST. LOUIS, MO.

careful correlation of facts and figures, instead of the usual compilation which one is accustomed to encounter under the heading. Careful study of this section will dispel much of the alarm created by those who for so long have harped upon the one string of the increase of cancer. It is to be hoped that American statisticians will be stimulated to remove the stigma which some of our foreign confreres have placed upon our methods of collecting data, so that, in future editions of "The Cancer Problem," the author will not be forced to accept the imputations made abroad.

The laboratory workers will find the section under "Histo-Pathology" a condensation of knowledge concerning the minute anatomy and pathology of cancer that must prove of great practical value, particularly as it is supplemented with a large number of histological plates and other illustrations. This section, together with that part of Section I which deals with the "History of Modern Cancer Research" and the section entitled "Cancer Research—A Resumé of the World's Work," will give much valuable data to those who are especially interested in the laboratory and purely experimental phases of the subject.

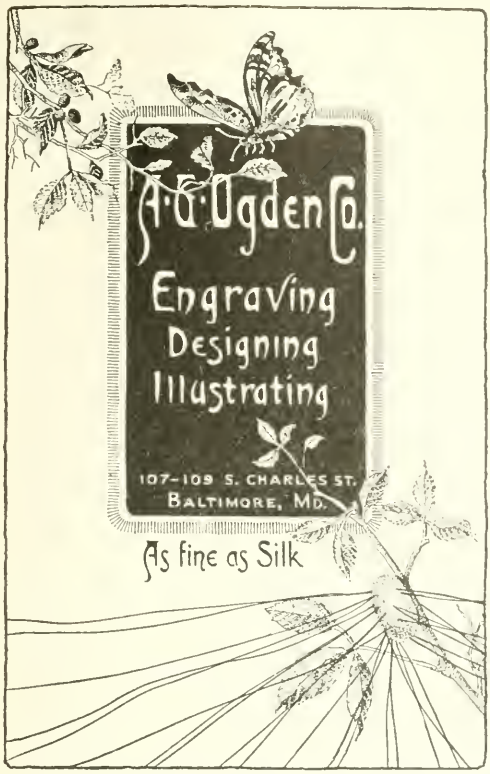
Just at this time, when not only medical societies, but women's clubs, mothers' congresses, and very nearly every other variety of organization are dabbling in cancer study, the section on the "Campaign of Education" will be found peculiarly pertinent. It is interesting to note that Dr. Bainbridge takes a very conservative stand on this particular question of educating the public with reference to cancer. In addition, the sections on "Prophylaxis," "Institutions for the Care of Cancer Patients," and "The Investigation of Cancer Cures" will give to propagandists much conservative, rational and logical matter which, if properly digested, will augur well for the victim of cancer and for those who, by virtue of age, sex, industrial or other predisposition, are fair subjects for the inroads of this disease.

The clinician, however, is always interested in the vital question, "What can I do for my patients?" Abundant answer to this question is found in the sections on "Clinical Course and Diagnosis" (including a valuable subdivision on "Possible Errors in Diagnosis"); "Non-Surgical Treatment"; "Surgical Treatment" (comprising the subdivisions "General Technic of Surgery as Applied to Cancer" and "Special Technic"), and a practical consideration of "Irremovable Cancer."

After reading Dr. Bainbridge's clear-cut exposition of the entire subject the reader will be in accord, we think, with the closing paragraph of the book: "While it cannot be gainsaid that the cancer problem today is still fraught with perplexity and uncertainty, one indisputable fact stands out in bold relief, serving as both guidepost and danger signal for the present and the future: If cancer be cut out soon enough a permanent cure is effected! This alone is sufficient to warrant the statement that we are 'traveling hopefully.'"

DEPARTMENT OF AGRICULTURE ADVISES THAT MILK BE PASTEURIZED AT LOW TEMPERATURES.

In order to determine the best way of pasteurizing milk so as to kill the disease germs, and yet not give the milk a cooked flavor or lessen its nutritive value, the Department of Agriculture,



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BACTERIAL tests show that the milk received by us primarily contains a lower average percentage of bacteria than is usual. It is then subjected to pasteurization after the most scientific and modern methods, thus giving us a distinctive product. Our hygienic plant, **No. 1117 Linden Avenue,** is at all times open to the inspection of physicians and others who are interested.

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Baltimore City Printing and Binding Company

353-363 EQUITABLE BUILDING

through its Dairy Division, has been conducting a series of experiments, treating milk at different temperatures and for different lengths of time. According to the report on these experiments in Bulletin 166 of the Bureau of Animal Industry, when milk is pasteurized at 145° F. for 30 minutes the chemical changes are so slight that it is unlikely that the protein (muscle-building element), or the phosphates of lime and magnesia are rendered less digestible than they are in raw milk.

Moreover, from a bacteriological standpoint, pasteurizing at low temperatures is found to be more satisfactory than pasteurizing at high temperatures. According to Bulletins 126 and 161, where low temperatures are used the majority of bacteria that survive are lactic acid organisms, which play an important part in the normal souring of milk. When milk is efficiently pasteurized at high temperatures, the bacteria which survive are largely of the putrefactive kinds, and milk so treated, if kept for any length of time, has a tendency to rot instead of sour. From the standpoint of economy, the technologist of the Dairy Division finds that pasteuring at low temperatures calls for less heat. It is found that it takes about 23½ per cent. less heat to raise milk to the temperature of 145° F. than to a temperature of 165° F. A similar gain is a saving of the ice needed, because it will require 23½ per cent. more refrigeration to cool milk to the shipping point when it is pasteurized at the higher temperature. The Department, therefore, recommends that "When market milk is pasteurized it should be heated to about 145° Fahr., and held at that temperature for 30 minutes."

THE REMOVAL FROM THE ESOPHAGUS OF A PLATE OF FALSE TEETH EMBEDDED FOR EIGHTEEN YEARS, BY MEANS OF ESOPHAGOSCOPE.

Dr. D. Braden Kyle, Philadelphia.

Paper read at the Thirty-fifth Annual Congress of American Laryngological Association, held May 5, 6 and 7, 1913, in Washington, D. C.

This foreign body which I present was very difficult to locate, in spite of its size and shape, on account of the granulation tissue which had organized into fibrous tissue, together with the curvature of the spine, as the X-ray picture shows. The patient swallowed the upper suction plate with four front teeth attached while sleeping. The plate lodged in his throat, and a physician who was called in wished to push it down into the stomach, to which the patient objected. He then went to a hospital, where, after the passage of several instruments, he was assured that he had never swallowed the plate, or that it was no longer in the esophagus. For a few weeks after the patient felt slight pain in the lower part of the neck at the point he always felt that the object had lodged. After that time there was no sensation, but swallowing has always been difficult. The Kahler esophagoscope was used, and many attempts were made before this foreign body was successfully removed. By loosening the plate from the fibrous bed by setting up slight inflammatory action and then waiting a few days, the plate was removed without much ulceration of the structure.

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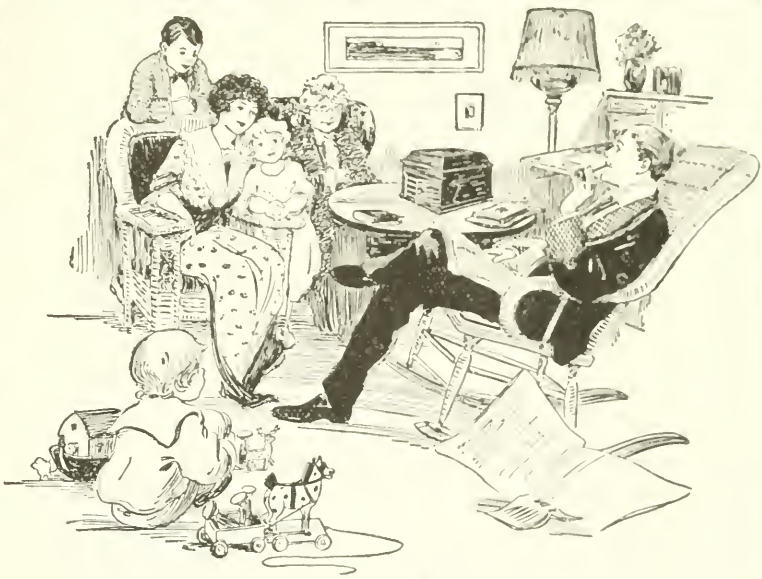

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damebas are also the cause of pyorrhea, ipecac, already well and favorably known in the treatment of amebiasis, has enjoyed greatly increased prominence and is today ranked as one of the most useful drugs.

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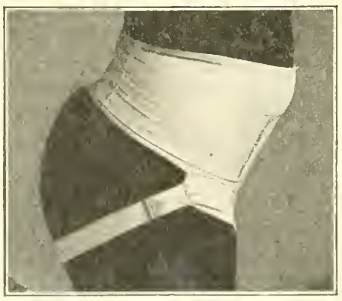

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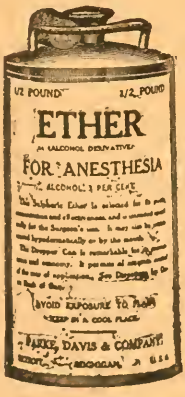

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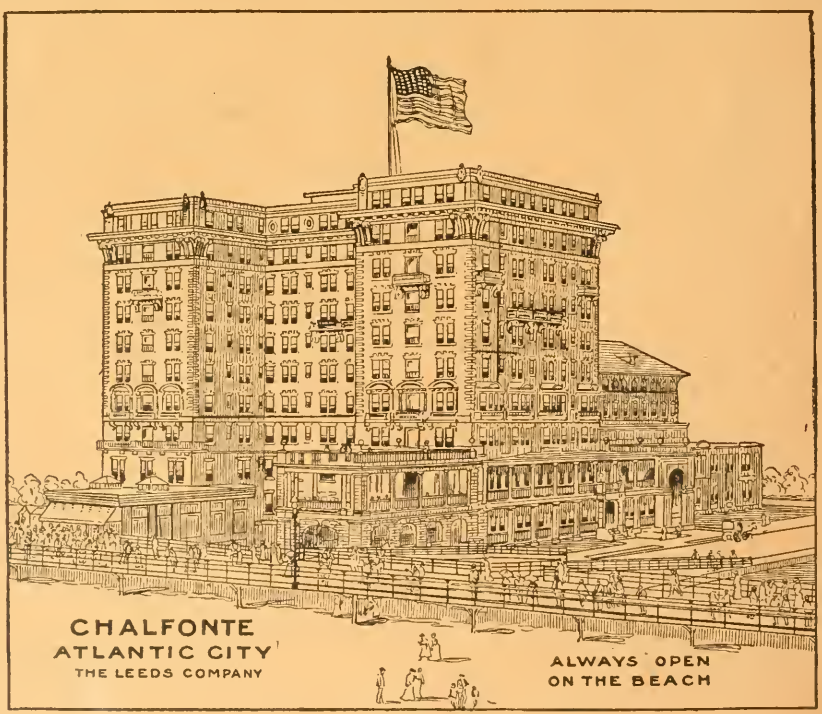

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